SERFF Tracking Number:	*UCTA-128460605*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental and Vision Insurance*		
Project Name/Number:	*/*		

Filing at a Glance

Company: The Order of United Commercial Travelers of America

Product Name: Dental and Vision Insurance	SERFF Tr Num: UCTA-128460605	State: Arkansas
TOI: H10I Individual Health - Dental	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: H10I.000 Health - Dental	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Authors: Denise Sharif, Jane Visocan, Lyndsay Fields	Disposition Date: 06/20/2012
	Date Submitted: 06/15/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 06/20/2012
	State Status Changed: 06/20/2012
Deemer Date:	Created By: Denise Sharif
Submitted By: Jane Visocan	Corresponding Filing Tracking Number:

Filing Description:

Please see the attached Cover Letter.

State Narrative:

Company and Contact

Filing Contact Information

Denise Sharif, Compliance Supervisor	dsharif@uct.org
1801 Watermark Dr.	614-487-9680 [Phone] 103 [Ext]

SERFF Tracking Number:	*UCTA-128460605*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental and Vision Insurance*		
Project Name/Number:	*/*		

Suite 100 614-487-9675 [FAX]
Columbus, OH 43215

Filing Company Information

The Order of United Commercial Travelers of America	CoCode: 56383	State of Domicile: Ohio
1801 Watermark Dr.	Group Code:	Company Type:
Suite 100	Group Name:	State ID Number:
Columbus, OH 43215	FEIN Number: 31-4273120	
(614) 487-9680 ext. 103[Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$300.00
Retaliatory?	Yes
Fee Explanation:	Ohio basis - $50 per company per filing = $50 Arkansas basis - $50 per company per form = $300
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Order of United Commercial Travelers of America	$300.00	06/15/2012	60183124

SERFF Tracking Number:	*UCTA-128460605*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental and Vision Insurance*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/20/2012	06/20/2012

SERFF Tracking Number:	*UCTA-128460605*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental and Vision Insurance*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 06/20/2012
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
The Order of United Commercial Travelers of America	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking Number:	*UCTA-128460605*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental and Vision Insurance*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Dental and Vision Insurance Policy	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Children's Rider	Approved-Closed	Yes
Form	Hearing Rider	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Replacement form	Approved-Closed	Yes
Rate	Dental and Vision Rates	Approved-Closed	Yes

SERFF Tracking Number:	*UCTA-128460605*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental and Vision Insurance*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/20/2012	DV 0312	Policy/Contract/Fraternal Certificate	Dental and Vision Insurance Policy	Initial		40.300	DV 0312.pdf
Approved-Closed 06/20/2012	DV OC 0312	Outline of Coverage	Outline of Coverage	Initial		42.300	DV OC 0312.pdf
Approved-Closed 06/20/2012	DVCR 0312	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Children's Rider	Initial		44.800	DVCR 0312.pdf
Approved-Closed 06/20/2012	HEBR 0312	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Hearing Rider	Initial		36.800	HEBR 0312.pdf
Approved-Closed 06/20/2012	DV APP 0612	Application/Enrollment Form	Application	Initial		41.400	DV APP 0612.pdf
Approved-Closed	DV REPL 0312	Other	Replacement form	Initial		30.000	DV REPL 0312.pdf

SERFF Tracking Number:	*UCTA-128460605*	*State:*	*Arkansas*
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Company Tracking Number:			
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Product Name:	*Dental and Vision Insurance*		
Project Name/Number:	*/*		

06/20/2012

The Order of United Commercial Travelers of America • A Fraternal Benefit Society
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 614.487.9675 • www.uct.org

DENTAL AND VISION EXPENSE INSURANCE POLICY

THIS IS A LIMITED BENEFIT POLICY WHICH ONLY PROVIDES BENEFITS FOR DENTAL AND VISION EXPENSES. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS, CONDITION OR INCAPACITY. THIS POLICY WILL NOT COVER ALL OF YOUR MEDICAL EXPENSES.

THIS IS A LEGAL CONTRACT BETWEEN THE OWNER AND US.

This is a contract between You and The Order of United Commercial Travelers of America (UCT). We issue this Policy based on the application signed by You and the payment of premiums as stated on the Policy Schedule Page. We will pay the benefits subject to all the terms and conditions of this Policy. This Policy begins on the Date of Issue listed on the Policy Schedule Page. Payment of each premium as it comes due will continue coverage to the next premium due date.

The Order of United Commercial Travelers of America will pay the benefits of this Policy for an Insured Loss subject to the provisions and limitations of the Policy.

IMPORTANT NOTICE: The issuance of this Policy is based on the Insured's answers to the questions on the application. A copy of the application is attached. Omissions or misstatements on the application could cause a claim to be denied or the Policy to be rescinded. If, for any reason the answers are incorrect, contact Us immediately at Our Home Office in Columbus, Ohio.

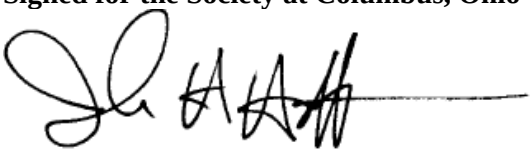
Thirty Day Right To Examine and Return Policy

Please read this Policy carefully. If, for any reason You are not satisfied, the Policy may be returned to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded.

Guaranteed Renewable for Life - Premium Subject to Change

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as underwriting class, state and zip code of residence. You will be notified at least thirty (30) days prior to any change in the table of rates becoming effective.

Signed for the Society at Columbus, Ohio



Chief Executive Officer

NOTICE TO BUYER: This is NOT a Medicare Supplement Policy. If You are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from Us.

NON-PARTICIPATING

Table of Contents

POLICY SCHEDULE PAGE

Policy Number: **[12345678]** **Policy Effective Date: [July 1, 2010]**

Insured Name: [John Doe] **Issue Age: [45]**

[Owner Name (if Insured is a minor): [Jane Doe]]

Mode At Issue: **Modal Premium:**

Policy Year Deductible: [$0 or $100]

Policy Year Maximum Benefit: [$750, $1,000, $1,500, $2000 or $2,500]

[Insured Children's Names: [Sally Doe] Issue Ages: [Age]
[Billy Doe] [Age]]

****

		Premium
Plan [1 or 2]		**$**
Rider(s):		
[Hearing Expense Benefit Rider		**$]**
[Dental & Vision Expense Children's Rider		**$]**
	Total Premium	**$**

Definitions

Covered Expense or Covered Loss refers to expenses incurred for Medically Necessary medical and dental services or supplies prescribed by a licensed medical professional. Covered Expenses may not be more than the Reasonable and Customary Charges for such services or supplies and will be deemed to be incurred on the date or dates such services or supplies are received by the Insured. Covered Expenses must be incurred while this Policy is in force.

Dentist refers to a person duly licensed and legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed, other than a member of the Insured's Immediate Family.

Experimental or Investigational Procedure or Treatment refers to the use of a treatment (drugs, devices and/or procedures) for a specific condition when all of the following are true:

1. the safety and effectiveness of a device is not proven; i.e. pre-market approval has not been granted (devices only);
2. benefits to at least one-third (1/3) of subjects are not documented in controlled clinical trials published in peer-reviewed English language medical journals; and
3. the treatment is not generally accepted medical practice as determined by review of peer-reviewed English language medical literature or authoritative medical journals or publications.

Immediate Family means Your spouse, parents, parents-in-law, step-parents, grandparents, grandparents-in-law, children, step-children, grandchildren, siblings and their respective spouses.

Injury means a bodily Injury which is the direct result of an accident and independent of all other causes that occurs after the Policy Effective Date and while this Policy is in force.

Insured refers to the person who is insured under this Policy. The Insured is as named in the application and shown on the Policy Schedule Page.

Medically Necessary means a service or supply that is required to diagnose or treat an Injury or Sickness and is:

1. prescribed by a Physician or other licensed medical professional;
2. consistent with the diagnosis and treatment of the Injury or Sickness;
3. in accordance with the generally accepted standards of medical practice; and
4. not solely for the convenience of You or the Physician or other licensed medical professional.

Ophthalmologist is a Physician duly licensed and legally entitled to practice ophthalmology at the time and in the state or jurisdiction in which services are performed, other than a member of the Insured's Immediate Family.

Optometrist is a Physician duly licensed and legally entitled to practice optometry at the time and in the state or jurisdiction in which services were performed, other than a member of the Insured's Immediate Family.

Owner refers to the person authorized to exercise the ownership rights under this Policy. The Owner is as named on the application or later endorsement. The Insured is the Owner unless the Insured is a minor.

Physician means any practitioner of the healing arts acting within the scope of his/her license, other than a member of the Insured's Immediate Family.

Policy Effective Date is the effective date of this Policy and is as shown on the Policy Schedule Page. The Policy Effective Date is not the date the application for coverage was signed.

Policy Year is a period of twelve months beginning each year on the month and day of the Policy Effective Date.

Policy Year Deductible refers to the dollar amount for which You are responsible during each Policy Year as shown on the Policy Schedule Page.

Definitions - Continued

Policy Year Maximum Benefit is the maximum amount We will pay during any Policy Year as shown on the Policy Schedule Page.

Pre-Existing Condition means a condition for which symptoms existed prior to the Policy Effective Date that would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice or treatment was recommended by a Physician or received from a Physician.

Preventative Dental Procedures refer to Cleaning, Examination and X-ray.

Reasonable and Customary Charge refers to the normal and prevailing charge, fee, or expense for the service rendered or for the material furnished in the geographic area where rendered or furnished.

Sickness means illness or disease with first manifests itself after the Policy Effective Date and while this Policy is in force.

Written Notice to the Company means a request in writing on forms furnished by or acceptable to the Company. All correspondence should be sent to Our Home Office at P.O. Box 159019, Columbus, Ohio 43215.

We, Our, Us, Society, Company, UCT means The Order of United Commercial Travelers of America.

You, Your, Yours means the Insured named on the Policy Schedule Page.

Benefit Provisions

[PLAN 1 - After the Policy Year Deductible is satisfied, the Company will pay the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:

1. 70% in the first Policy Year;
2. 80% in the second Policy Year;
3. 80% in the third Policy Year; and
4. 90% thereafter.

Covered Expenses, subject to the Limitations and Exclusions, are:

Dental Benefits
We will pay the applicable percentage for fillings, non-routine X-rays and a maximum of (4) four simple extractions during the first Policy Year.

After the policy has been in force three (3) months, the Company will pay the first visit up to $125 for routine Dental Cleaning, Examination and X-ray. After the policy has been in force twelve (12) months, routine Dental Cleaning, Examination and X-ray are payable twice per year with up to $125/$75 alternating toward Preventative Dental Procedures. In the first policy year the amount payable up to the $125.00 benefit will be applicable. Beginning in the second policy year, the amount payable up to $125.00 will be applied to the first visit and up to $75 to the second visit. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit. Services performed by a licensed Dentist to include a routine examination, cleaning and x-ray.

We will NOT pay any benefits for Major Dental Services such as:
Bridges, crowns, full dentures or partials, any work relating to replacement of teeth, “full mouth” extractions, and root canal.

Vision Benefits
We will pay the applicable percentage for visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of $150 in any twenty-four (24) month period.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for existing eyeglasses or contact lens (including the renewal or changing of prescriptions).**]**

[PLAN 2 - After the Policy Year Deductible is satisfied, the Company will pay the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:

1. 60% in the first Policy Year;
2. 70% in the second Policy Year;
3. 80% in the third Policy Year; and
4. 90% thereafter.

Covered Expenses, subject to the Limitations and Exclusions, are:

Dental Benefits
We will pay the applicable percentage for fillings, non-routine X-rays and a maximum of (4) four simple extractions during the first Policy Year.

After the policy has been in force three (3) months, the Company will pay the first visit up to $125 for routine Dental Cleaning, Examination and X-ray. After the policy has been in force twelve (12) months, routine Dental Cleaning, Examination and X-ray are payable twice per year with up to $125/$75 alternating toward Preventative Dental Procedures. In the first policy year the amount payable up to the $125.00 benefit will be applicable. Beginning in the second policy year, the amount payable up to $125.00 will be applied to the first visit and up to $75 to the second visit. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit. Services performed by a licensed Dentist to include a routine examination, cleaning and x-ray.

After the policy has been in force twelve (12) months, We will pay the applicable percentage for dental services performed by a licensed Dentist to include bridges, crowns, full dentures or partials, “full mouth” extractions, and root canals.

Vision Benefits
We will pay the applicable percentage for visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of $150 in any twenty-four (24) month period.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for existing eyeglasses or contact lens (including the renewal or changing of prescriptions).**]**

Limitations and Exclusions

This Policy has a Policy Year Deductible as shown on the Policy Schedule Page. Once the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit as shown on the Policy Schedule Page.

We will NOT pay benefits for:

1. any loss resulting from war, declared or undeclared; or
2. any intentionally self-inflicted Injury; or
3. any loss resulting from the commission of or the attempt to commit an assault or felony; or
4. any loss resulting from engaging in any illegal activity or occupation; or
5. any services that are not recommended by a Physician or other licensed medical professional; or
6. any Experimental or Investigational Procedure or Treatment; or
7. orthodontic treatment; or
8. implants; or
9. occlusal guards, adjustments; or
10. any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ); or
11. expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed for the treatment of cataracts); or
12. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; or
13. prescription drugs; or
14. charges in excess of Reasonable and Customary Charges; or
15. treatment or diagnosis received while outside the United States of America or its territories; or
16. services for which you are not liable or for which no charge normally is made in the absence of insurance; or
17. loss that occurs while this Policy is not in force.

General Provisions

Entire Contract; Changes – This Policy, including the application, endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by one of the Company's officers and unless such approval shall be endorsed hereon or attached hereto. No agent or officer of any Local, Grand or Supreme Council has authority to change this Policy or to waive any of its provisions.

Time Limit On Certain Defenses (Contestable Period) – Statements in the application are considered representations, not warranties. Statements may be used to contest the validity of this Policy or in defense of a claim only if they are contained in an attached application or endorsement. The Company cannot contest this Policy after it has been in force two years during the Insured's lifetime, from the Policy Effective Date.

Grace Period – A Grace Period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium. This Policy shall continue in force during any Grace Period.

Reinstatement – If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to any Sickness as may begin more than ten (10) days after that date. In all other respects, We and You shall have the

same rights there under as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

Notice of Claim – We must receive written Notice of Claim within twenty (20) days after any Covered Loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on Your behalf to the Society at Our Home Office at 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

Claim Forms – When We get a Notice of Claim, We will send You forms for filing Proof of Loss. If We do not send the forms within fifteen (15) working days after receiving Written Notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within ninety (90) days after the date the loss began or occurred.

Proof of Loss – We must receive written Proof of Loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the Insured making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

Time of Payment of Claims – All benefits payable under this Policy will be payable immediately upon receipt of due Proof of Loss.

If We do not pay benefits upon receipt of due Proof of Loss, We shall have fifteen (15) working days to mail to You a letter or notice which states the reasons We have for not paying the claim, either in whole or in part, including an itemization of any documents or other information needed to process the claim or any portions thereof which have not been paid. Once all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

Payment of Claims – We will pay all benefits to You; benefits under this Policy are not subject to assignment. Any benefits unpaid at Your death will be paid to Your estate or Your designated beneficiary.

Legal Actions – No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written Proof of Loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written Proof of Loss is required to be furnished.

Misstatement Of Age or Sex – If the Insured's age or sex has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age and sex.

Unpaid Premium: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Pro Rata Refund: If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

Cancellation By Insured – You may cancel this Policy at any time by Written Notice to the Company delivered or mailed to Us. Cancellation will be effective upon receipt of the Written Notice or on a later date as specified in the notice. In the event of cancellation of this Policy, We shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the date of the cancellation.

Insurance coverage will terminate automatically as of the premium due date if premium for this Policy is in default beyond the end of the Grace Period.

Conformity With State Statute – Any provision of the Policy which, on the Policy Effective Date, is in conflict with the laws of the state in which the Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Clerical Error – Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof documenting any clerical errors must be supplied.

Maintenance of Solvency – UCT's constitution provides that in the event that its reserves as to all or any class of contracts of insurance issued by it become impaired, the Board of Governors may require that these shall be paid by each Owner of such contract of insurance to UCT an amount equal to such Owner's equitable portion of such deficiency as ascertained by the Board of Governors.

If payment of the amount required is not made by such Owner, then either or both of the following, at the election of the Owner, shall apply:

1. the amount shall stand as Indebtedness against the contract of insurance and shall bear interest at a rate not to exceed ten percent (10%) per annum; or
2. the Owner shall accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The Owner shall make such election by notifying the Board of Governors of his or her election on a form prescribed by the Board of Governors that shall be provided to each Owner. Failure to make such election shall result in a presumption that the Owner elects to accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The Owner hereby agrees that if they affirmatively elect to have the amount stand as Indebtedness against the contract of insurance, then UCT may offset the amount of such Indebtedness together with interest thereon against any payment of benefits under this contract of insurance.

Suspension or Expulsion – If the Owner should be expelled or suspended from the membership in the Society for any reason, except nonpayment of premium or within the Contestable Period for misrepresentation on the Owner's application for membership, the Owner shall have the privilege of maintaining this Policy in force by continuing payment of the required premium.

DENTAL AND VISION EXPENSE POLICY
A LIMITED BENEFIT INSURANCE POLICY

NON-PARTICIPATING

The Order of United Commercial Travelers of America • A Fraternal Benefit Society
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 614.487.9675 • www.uct.org

DENTAL AND VISION EXPENSE INSURANCE POLICY

THIS IS A LIMITED BENEFIT POLICY WHICH ONLY PROVIDES BENEFITS FOR DENTAL AND VISION EXPENSES. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS, CONDITION OR INCAPACITY. THIS POLICY WILL NOT COVER ALL OF YOUR MEDICAL EXPENSES.

OUTLINE OF COVERAGE POLICY FORM DV 0312

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and United Commercial Travelers of America. It is therefore important that you **READ YOUR POLICY CAREFULLY.**

Dental and Vision only coverage is designed to provide you with coverage for certain losses for dental and vision **ONLY**, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

BENEFIT PLAN OPTIONS

PLAN 1: After the Policy Year Deductible is satisfied, the Company will pay the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:

1. 70% in the first Policy Year;
2. 80% in the second Policy Year;
3. 80% in the third Policy Year; and
4. 90% thereafter.

Covered Expenses, subject to the Limitations and Exclusions, are:

Dental Benefits
We will pay the applicable percentage for fillings, non-routine X-rays and a maximum of (4) four simple extractions during the first Policy Year.

After the policy has been in force three (3) months, the Company will pay the first visit up to $125 for routine Dental Cleaning, Examination and X-ray. After the policy has been in force twelve (12) months, routine Dental Cleaning, Examination and X-ray are payable twice per year with up to $125/$75 alternating toward Preventative Dental Procedures. In the first policy year the amount payable up to the $125.00 benefit will be applicable. Beginning in the second policy year, the amount payable up to $125.00 will be applied to the first visit and up to $75 to the second visit. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit. Services performed by a licensed Dentist to include a routine examination, cleaning and x-ray.

We will NOT pay any benefits for Major Dental Services such as:
Bridges, crowns, full dentures or partials, any work relating to replacement of teeth, “full mouth” extractions, and root canal.

Vision Benefits
We will pay the applicable percentage for visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of $150 in any twenty-four (24) month period.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for existing eyeglasses or contact lens (including the renewal or changing of prescriptions).

OR

PLAN 2: After the Policy Year Deductible is satisfied, the Company will pay the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:

1. 60% in the first Policy Year;
2. 70% in the second Policy Year;
3. 80% in the third Policy Year; and
4. 90% thereafter.

Covered Expenses, subject to the Limitations and Exclusions, are:

Dental Benefits
We will pay the applicable percentage for fillings, non-routine X-rays and a maximum of (4) four simple extractions during the first Policy Year.

After the policy has been in force three (3) months, the Company will pay the first visit up to $125 for routine Dental Cleaning, Examination and X-ray. After the policy has been in force twelve (12) months, routine Dental Cleaning, Examination and X-ray are payable twice per year with up to $125/$75 alternating toward Preventative Dental Procedures. In the first policy year the amount payable up to the $125.00 benefit will be applicable. Beginning in the second policy year, the amount payable up to $125.00 will be applied to the first visit and up to $75 to the second visit. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit. Services performed by a licensed Dentist to include a routine examination, cleaning and x-ray.

After the policy has been in force twelve (12) months, We will pay the applicable percentage for dental services performed by a licensed Dentist to include bridges, crowns, full dentures or partials, “full mouth” extractions, and root canals.

Vision Benefits
We will pay the applicable percentage for visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of $150 in any twenty-four (24) month period.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for existing eyeglasses or contact lens (including the renewal or changing of prescriptions).

Limitations and Exclusions

This Policy has a Policy Year Deductible as shown on the Policy Schedule Page. Once the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit as shown on the Policy Schedule Page.

Plan 1- we will NOT pay any benefits for Major Dental Services such as:

Bridges, crowns, full dentures or partials, any work relating to replacement of teeth, "full mouth" extractions, and root canal.

Plan 2 - we will NOT pay benefits during the first Policy Year (12 months) for the following items and/or services:

Bridges, crowns, full dentures or partials, "full mouth" extractions, and root canals.

This Policy has a Policy Year Deductible as shown on the Policy Schedule Page. Once the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit as shown on the Policy Schedule Page.

We will NOT pay benefits for:

1. any loss resulting from war, declared or undeclared; or
2. any intentionally self-inflicted Injury; or
3. any loss resulting from the commission of or the attempt to commit an assault or felony; or
4. any loss resulting from engaging in any illegal activity or occupation; or
5. any services that are not recommended by a Physician or other licensed medical professional; or
6. any Experimental or Investigational Procedure or Treatment; or
7. orthodontic treatment; or
8. implants; or
9. occlusal guards, adjustments; or
10. any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ); or
11. expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed for the treatment of cataracts); or
12. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; or
13. prescription drugs; or
14. charges in excess of Reasonable and Customary Charges; or
15. treatment or diagnosis received while outside the United States of America or its territories; or
16. services for which you are not liable or for which no charge normally is made in the absence of insurance; or
17. loss that occurs while this Policy is not in force.

RENEWABILITY. The policy is guaranteed renewable for life. We will renew the policy each time you send us a premium. It must be paid on or before the date it is due or during the 31 days that follow.

PREMIUM CHANGE. We may change the premium rates for the policy. The change will be based on a new table of rates. We can only change the premium if we change it for all policies like yours in your class and in the same state where your policy was issued.

The Order of United Commercial Travelers of America • A Fraternal Benefit Society
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 614.487.9675 • www.uct.org

Dental and Vision Expense Insurance
Children's Rider to Age 23

RIDER EFFECTIVE DATE: _____ POLICY #: _____

RIDER TAKING EFFECT AND RENEWAL: We have issued this Rider in consideration of the payment of premium and the statements in the application. The application is part of the Policy to which this Rider is attached. The Effective Date of this Rider is the same as the Effective Date of the Policy to which this Rider is attached, unless otherwise indicated. You can keep this Rider in force, as long as You renew the Policy, by paying premiums as they become due.

This Rider is subject to all of the terms, provisions, definitions and exclusions of the Policy plan unless otherwise noted in this Rider. Information about Your Rider coverage, including its Effective Date and coverage limits are shown on the Policy Schedule Page.

DEFINITIONS – Insured Children as used herein means:

1. Any dependent children which includes natural, adopted and stepchildren as well as a children under legal guardianship, who live with the insured "parent"; and,
2. Any children, born to the Insured, or who may be legally adopted by the Insured while such children are less than 18 years of age; and,
3. One child or multiple children (combined).

BENEFIT - We will pay the applicable percentage for dental and/or vision expenses performed by a licensed Physician or Dentist not to exceed the Policy Year maximum for one or all Insured Children combined.

After the policy has been in force three (3) months, the Company will pay for the first visit not to exceed $125 for a routine Dental Cleaning, Examination and X-ray. After the policy has been in force twelve (12) months, routine Dental Cleaning, Examination and X-ray are payable twice per year not to exceed $125/$75 alternating toward Preventative Dental Procedures. For one or all insured children combined:

- first policy year, the amount payable up to the $125.00 benefit will be applicable; and
- second policy year, the amount payable up to $125.00 will be applied to the first visit and up to $75 to the second visit.

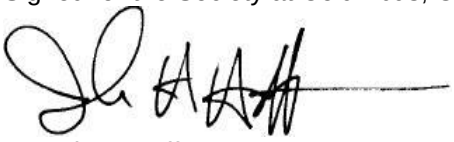
This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit. Services performed by a licensed Dentist to include a routine Dental Cleaning, Examination, and X-ray. Benefits will terminate for each child on the Policy Anniversary following his or her attainment of age 23.

RIDER PREMIUM - There is an additional premium charge for this rider.

TERMINATION OF RIDER - This rider will end on the earliest of the following:

1. on the date the policy terminates; or
2. on the Policy Anniversary on or following attainment of Age 23 of the youngest insured child; or
3. on the date the Insured dies.

Signed for the Society at Columbus, Ohio



Joseph H. Hoffman
Chief Executive Officer

MEMBER OF THE AMERICAN FRATERNAL ALLIANCE

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1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619
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Hearing Expense Benefit Rider

RIDER EFFECTIVE DATE: _____ POLICY #: _____

This is an additional benefit to the contract of insurance between The Order of United Commercial Travelers of America and the owner of the Dental and Vision Expense Insurance policy to which this rider is attached. It has the same Effective Date as the policy date shown on the Policy Data page of the policy. It is issued in consideration of the statements made in the application and the payment of the premium as shown on the Schedule of Benefits and Premiums in the policy. It is subject to the definitions, provisions, exceptions, limitations and exclusions of the policy which are not inconsistent with the provisions of this rider.

DEFINITIONS

Audiologist refers to a person duly licensed and legally entitled to practice audiology at the time and in the state or jurisdiction in which services are performed, other than a member of the Insured's Immediate Family.

First Time means the Insured has never owned, purchased or worn a hearing aid(s).

BENEFIT - We will pay the applicable percentage for hearing examinations performed by a Physician or Audiologist, including the cost of First Time hearing aids and any necessary repairs.

RIDER PREMIUM - There is an additional premium charge for this rider.

EXCLUSIONS - The Hearing Expense Benefit will not be available:

1. during the first Policy Year (12 months) for repair or replacement of existing hearing aids; and
2. the Limitations and Exclusions referenced in the policy this rider is attached to.

TERMINATION OF RIDER - This rider will end on the earliest of the following:

1. the date the policy terminates; or
2. on the policy anniversary on or following attainment of age 85; or
3. the date the Insured dies.

Signed for the Society at Columbus, Ohio

Joseph H. Hoffman
Chief Executive Officer

UCT Where Community and Compassion Unite

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APPLICATION FOR DENTAL AND VISION INSURANCE POLICY

Requested Effective Date of Policy

APPLICANT

Last *First* *MI*

AGE	**DATE OF BIRTH**			**SEX**
	Month	*Day*	*Year*	☐ Male ☐ Female

SOCIAL SECURITY NUMBER

APPLICANT'S ADDRESS

Street: _____

_____

_____

City: _____

State: _____ *Zip Code:* _____

Area Code: _____ *Telephone Number:* _____

*Email Address:*_____

[OWNER *(if applicant is a minor)*

[*Last* *First* *MI*

Area Code: _____ *Telephone Number:* _____

*Email Address:*_____**]**

[OWNER'S ADDRESS]

[*Street:* _____

_____

City: _____

State: _____ *Zip Code:* _____**]**

Are you a member of The Order of United Commercial Travelers of America? ☐ **Yes** ☐ **No**

Council Name:_____ **Council Location (City & State)** _____

Is anyone else who resides in your household also applying for the Dental and Vision Insurance Policy? If yes, please complete. ☐ **Yes** ☐ **No**

Name _____ *Name* _____

Name _____ *Name* _____

(Please list any additional individuals on a separate paper and attach to the application.)

MEDICAL INFORMATION

		APPLICANT
1.	Do you currently wear dentures?	☐ Yes ☐ No
2.	Have you been advised to have any dental work which has not been completed? If "Yes", provide details: _____	☐ Yes ☐ No
3.	Do you currently wear eyeglasses or contact lens?	☐ Yes ☐ No
4.	Have you received advice or treatment within the past nine (9) months for correction of a vision problem? If "Yes", provide details: _____	☐ Yes ☐ No
5.	[Are you age 60 and over and did you choose Plan 2? If yes, please answer questions 6 through 8.]	[☐ Yes ☐ No]
6.	[Do you currently wear a hearing aid?]	[☐ Yes ☐ No]
7.	[Have you been treated for hearing loss within the past nine (9) months?]	[☐ Yes ☐ No]
8.	[Has a physician recommended the purchase of a hearing aid to correct a hearing deficiency?]	[☐ Yes ☐ No]

BENEFIT OPTIONS					
Plan		**☐ [1 – Basic]**		**☐[2 – Premier or Basic + Major]**	
Policy Year Maximum	**[☐ $750]**	**[☐ $1,000]**	**[☐ $1,500]**	**[☐ $2,000]**	**[☐ $2,500]**
Deductible		**[☐$0]**		**[☐ $100]**	
Rider[s]		**[☐ Hearing Rider] [(required if age 60 and above and choosing Plan 2)]**		**[☐ Children's Rider]**	

[If Children's Rider is elected, list names of your children (under age 18) to be insured. FIRST MI LAST]	**[Relationship of Child to Applicant]**	**[Gender]**	**[Date of Birth - Month/Day /Year]**
		[☐ Male ☐ Female]	
		[☐ Male ☐ Female]	
		[☐ Male ☐ Female]	
[*(Please list additional children on a separate paper and attach to the application.)*]			

BILLING TYPE	**MODE OF PAYMENT**		
☐ Individual	**☐ Annual**	**☐ Semi-annual**	**☐ Quarterly**
☐ Worksite	**☐ Monthly EFT**	**☐ List Bill**	

[Plan 1 or Plan 2 Premium] **$ _____**

[Children's Rider Premium] **$ _____**

[Hearing Rider Premium] **$ _____**

SUBTOTAL **$ _____**

Less Household Discount (If Applicable) **$ _____**

TOTAL MODAL PREMIUM **$ _____**

Modal Fraternal Dues (If Applicable) **$ _____**

TOTAL MODAL AMOUNT DUE **$ _____**

TOTAL AMOUNT PAID WITH APPLICATION **$ _____**
(if EFT, initial premium may be drafted)

REPLACEMENT INFORMATION (MUST BE COMPLETED)

APPLICANT

1. Do you have any dental or vision insurance currently in force? ☐ Yes ☐ No
2. Is the insurance applied for intended to replace any existing insurance with this or any other company? ☐ Yes ☐ No
   If "Yes", with which company: (Name and address): _____
   _____
   Policy Number: _____ If that policy lapsed, when did it lapse? _____
3. If replacement is involved, have you received a replacement form (in states where required by law)? ☐ Yes ☐ No

APPLICATION AGREEMENT

I hereby apply to The Order of United Commercial Travelers of America (UCT) for a policy to be issued in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. I understand that any change in my health prior to delivery of this policy may be used in the underwriting evaluation process. I have received an outline of coverage for the policy applied for.

If not a current member of The Order of United Commercial Travelers of America, I apply to become a member as indicated by my signature below. I understand UCT is a fraternal benefit society and agree to abide by the Society's Constitution and Bylaws.

FRAUD WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signature of Applicant	**Date**
[Signature of Owner *(if applicant is a minor)***]**	**[Date]**

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____
_____
_____
_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____
_____
_____
_____

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for to the Applicant.

Agent's Signature	**Date**
Agent's Printed Name	**Agent No.**
Agent Email:	

AUTHORITY TO HONOR PREMIUM CHECKS - ATTACH VOIDED CHECK
Deposit Slips NOT Accepted

AUTHORIZATION

IN FAVOR OF: **The Order of United Commercial Travelers of America**
1801 Watermark Drive, Suite 100, Box 159019, Columbus, Ohio 43215-8619.

Name of Bank Customer: ☐ **Checking**

Insured's Name: ☐ **Savings**

Routing Number: _____ **Account Number:** _____

To (Name of Bank): _____
Address of Bank:

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Date	**Signature of Bank Customer**

AUTHORIZATION

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

To: Bank above:

In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

Where Community and Compassion Unite

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NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application and the information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by The Order of United Commercial Travelers of America. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concern your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature of Agent, Broker or Other Representative)

_____

Print Name and Address of Agent

The above "Notice to Applicant" was delivered to me on:

_____ _____

(Applicant's Signature) **(Date)**

SERFF Tracking Number:	*UCTA-128460605*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental and Vision Insurance*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type: %

Overall Percentage of Last Rate Revision: 0.000%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
The Order of United Commercial Travelers of America	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking Number:	*UCTA-128460605*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental and Vision Insurance*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved-Closed 06/20/2012	Dental and Vision Rates	DV 0312	New		Dental-Vision Rates.pdf

THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA
Dental and Vision Product - Form DV 0312
Exhibit B - Gross Annual Premium Rates

Base Policy - Plan 1 (Basic Dental, No Major Services)

	$750 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
Children	231.00	203.00
Child	210.00	184.00
18-39	221.00	193.00
40-59	238.00	209.00
60-74	265.00	233.00
75-79	282.00	249.00
80-84	300.00	264.00

	$1,000 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
Children	257.00	226.00
Child	233.00	205.00
18-39	246.00	215.00
40-59	265.00	233.00
60-74	295.00	258.00
75-79	314.00	276.00
80-84	334.00	293.00

	$1,500 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
Children	334.00	293.00
Child	302.00	266.00
18-39	318.00	279.00
40-59	347.00	305.00
60-74	379.00	332.00
75-79	394.00	345.00
80-84	410.00	359.00

	$2,000 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
Children	381.00	335.00
Child	345.00	303.00
18-39	363.00	319.00
40-59	391.00	343.00
60-74	426.00	375.00
75-79	444.00	390.00
80-84	462.00	405.00

	$2,500 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
Children	415.00	365.00
Child	377.00	331.00
18-39	396.00	348.00
40-59	426.00	374.00
60-74	465.00	409.00
75-79	484.00	425.00
80-84	504.00	442.00

Modal Factors
Direct-Billed
Annual = 1
Semi-annual = 0.515
Quarterly = 0.2625
Monthly = .1000

Modal Factors
Automatic Bank Withdrawal
Annual = 1
Semi-annual = 0.515
Quarterly = 0.2625
Monthly = .08333

Household discount - if two or more people, living in the same household at the same address, apply for coverage then each may receive a 10% premium discount.

THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA
Dental and Vision Product - Form DV 0312
Exhibit B - Gross Annual Premium Rates

Base Policy - Plan 2 (Includes Major Services)

	$750 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
Children	305.00	267.00
Child	276.00	242.00
18-39	324.00	285.00
40-59	351.00	308.00
60-74	390.00	342.00
75-79	416.00	365.00
80-84	442.00	387.00

	$1,000 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
Children	339.00	297.00
Child	307.00	270.00
18-39	361.00	317.00
40-59	390.00	342.00
60-74	434.00	380.00
75-79	462.00	406.00
80-84	491.00	431.00

	$1,500 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
Children	439.00	385.00
Child	398.00	349.00
18-39	468.00	411.00
40-59	509.00	447.00
60-74	557.00	488.00
75-79	579.00	508.00
80-84	602.00	528.00

	$2,000 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
Children	501.00	440.00
Child	455.00	399.00
18-39	534.00	469.00
40-59	574.00	504.00
60-74	627.00	550.00
75-79	653.00	572.00
80-84	679.00	596.00

	$2,500 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
Children	546.00	480.00
Child	496.00	435.00
18-39	583.00	512.00
40-59	626.00	549.00
60-74	683.00	600.00
75-79	712.00	624.00
80-84	740.00	650.00

Modal Factors
Direct-Billed
Annual = 1
Semi-annual = 0.515
Quarterly = 0.2625
Monthly = .1000

Modal Factors
Automatic Bank Withdrawal
Annual = 1
Semi-annual = 0.515
Quarterly = 0.2625
Monthly = .08333

Household discount - if two or more people, living in the same household at the same address, apply for coverage then each may receive a 10% premium discount.

THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA
Dental and Vision Product - Form DV 0312
Exhibit B - Gross Annual Premium Rates

Hearing rider - Form HEBR 0312

	$750 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
Children	17.00	15.00
Child	15.00	14.00
18-39	18.00	16.00
40-59	19.00	17.00
60-74	21.00	19.00
75-79	23.00	20.00
80-84	24.00	21.00

	$1,000 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
Children	19.00	17.00
Child	17.00	15.00
18-39	20.00	18.00
40-59	21.00	19.00
60-74	24.00	21.00
75-79	25.00	22.00
80-84	27.00	24.00

	$1,500 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
Children	24.00	22.00
Child	22.00	20.00
18-39	26.00	23.00
40-59	28.00	24.00
60-74	30.00	27.00
75-79	32.00	28.00
80-84	34.00	29.00

	$2,000 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
Children	27.00	24.00
Child	25.00	22.00
18-39	29.00	26.00
40-59	32.00	27.00
60-74	35.00	30.00
75-79	36.00	32.00
80-84	38.00	33.00

	$2,500 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
Children	30.00	26.00
Child	27.00	24.00
18-39	32.00	29.00
40-59	34.00	30.00
60-74	38.00	33.00
75-79	39.00	34.00
80-84	41.00	35.00

Modal Factors
Direct-Billed
Annual = 1
Semi-annual = 0.515
Quarterly = 0.2625
Monthly = .1000

Modal Factors
Automatic Bank Withdrawal
Annual = 1
Semi-annual = 0.515
Quarterly = 0.2625
Monthly = .08333

Household discount - if two or more people, living in the same household at the same address, apply for coverage then each may receive a 10% premium discount.

SERFF Tracking Number:	*UCTA-128460605*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental and Vision Insurance*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	06/20/2012

Comments:
Please see the attached.
Attachments:
Readability Certification 6 12.pdf
Reg 19 Certification.pdf
Reg 49 Certification.pdf
AR Consumer Notice.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	06/20/2012

Comments:
The application is included under the Forms Tab as DV APP 0612.

		Item Status:	Status Date:
Satisfied - Item:	Health - Actuarial Justification	Approved-Closed	06/20/2012

Comments:
Please see the attached.
Attachment:
DVH AJ 4-25-12.pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	06/20/2012

Comments:
The Outline of Coverage is included under the Forms Tab as DV OC 0312.

SERFF Tracking Number:	*UCTA-128460605*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental and Vision Insurance*		
Project Name/Number:	*/*		

		Item Status:	**Status Date:**
Satisfied - Item:	Cover Letter	Approved-Closed	06/20/2012

Comments:

Please see the attached.

Attachment:

AR Cover Letter.pdf

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

The Order of United Commercial Travelers of America
1801 Watermark Dr., Suite 100
Columbus, OH 43215

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

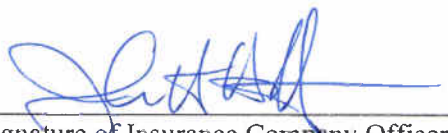
Title of Form	Form Number	Flesch Score	
		Stand-Alone	Combined with Policy Form
Dental and Vision Expense Policy	DV 0312	40.3	n/a
Outline of Coverage	DV OC 0312	42.3	n/a
Children's Rider	DVCR 0312	44.8	n/a
Hearing Rider	HEBR 0312	36.8	40.1
Application	DV APP 0612	41.4	n/a
Replacement Form	DV REPL 0312	30.0	40.3

In determining the Flesch Scores shown above, the following "text" was excluded:

1. The name and address of the company;
2. The name, number and title of the form;
3. The table of contents or index;
4. Captions and sub-captions;
5. Specification pages, schedules and tables;
6. Any provisions required by federal law or regulation; and
7. Any medical terminology.

The type size of the text is at least 10-point.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in the state.



Signature of Insurance Company Officer

ARKANSAS
Rule and Regulation 19 Certification

Title of Form(s)	Form Number
Dental and Vision Expense Policy	DV 0312
Dental and Vision Outline of Coverage	DV OC 0312
Dental and Vision Children's Rider	DVCR 0312
Dental and Vision Hearing Rider	HEBR 0312
Dental and Vision Application	DV APP 0612
Dental and Vision Replacement Form	DV REPL 0312

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 19, the Unfair Sex Discrimination in the Sale of Insurance.

Signature

Joseph Henry Hoffman

Name

Chief Executive Officer

Title

ARKANSAS
Rule and Regulation 49 Certification

Title of Form(s)	Form Number
Dental and Vision Expense Policy	DV 0312
Dental and Vision Outline of Coverage	DV OC 0312
Dental and Vision Children's Rider	DVCR 0312
Dental and Vision Hearing Rider	HEBR 0312
Dental and Vision Application	DV APP 0612
Dental and Vision Replacement Form	DV REPL 0312

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 49, the Life & Health Guaranty Association Notice.

Signature

Joseph Henry Hoffman

Name

Chief Executive Officer

Title

Consumer Notice
The Order of United Commercial Travelers of America

Policyholder Service Office:	**1801 Watermark Drive, Suite 100** **Columbus, Ohio 43215-8619**
Telephone Number:	**800-848-0123**
Name of Agent:	**[Fred Smith]**
Agent Address:	**[123 First Street, Any Town, Arkansas]**
Agent Telephone Number:	**[555-555-1234]**

If we at The Order of United Commercial Travelers of America fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-800-852-5494 or 1-501-371-2460

June 14, 2012

Arkansas Insurance Department
1200 W. Third St.
Little Rock, AR 72201

RE: The Order of United Commercial Travelers of America
NAIC # 56383/ FEIN 31-4273120

SUBMISSION

Dental and Vision Insurance Policy Form Number DV 0312
Outline of Coverage Form Number DV OC 0312
Children's Rider Form Number DVCR 0312
Hearing Expense Rider Form Number HEBR 0312
Application Form Number DV APP 0612
Replacement Form Number DV REPL 0312

We are requesting the Department's review and approval of this new product filing.

Any required filing documents have been completed and are included with the filing.

The benefits for dental and vision are paid after the annual policy deductible is met, by a percentage of actual charges, not to exceed reasonable and customary charges for covered expenses up the policy year maximum benefit. The percentages are based on the number of years the policy is in force as follows:

PLAN 1	OR	PLAN 2
(Basic)		(Basic + Major)
Policy Year 1 – 70%		Policy Year 1 – 60%
Policy Year 2 – 80%		Policy Year 2 – 70%
Policy Year 3 – 80%		Policy Year 3 – 80%
Policy Year 4+ - 90%		Policy Year 4+ - 90%

The available annual deductible amounts are $0 and $100. The policy year maximum benefit amounts are $750, $1,000, $1,500, $2,000 or $2,500.

The policy is guaranteed renewable. Issue age range is from age 0 through age 84. Underwriting is on a simplified issue basis with yes/no questions. The policy will be marketed by licensed brokers and agents in your state.

The Actuarial Memorandum and Rates are included with this filing.

We appreciate the Department's time and consideration of this filing. Thank you.

Sincerely,

Denise Sharif
Compliance Supervisor
(800) 848-0123, Ext. 103
Email: dsharif@uct.org